Department of the Army
Pamphlet 600–63–11

Personnel—General

“Fit To Win” Dental Health

Headquarters
Department of the Army
Washington, DC
1 September 1987

UNCLASSIFIED

SUMMARY of CHANGE

DA PAM 600–63–11
“Fit To Win”
Dental Health

Not applicable.

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"Fit To Win" Dental Health

By Order of the Secretary of the Army:

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History. This publication has been reorganized to make it compatible with the Army electronic publishing database. No content has been changed.

Summary. Not applicable.

Applicability. This guidance applies to installation commanders and members of installation/community health promotion councils. This includes but is not limited to: Director of Personnel and Community Activities (DPCA); Director of Logistics (DOL); Public Affairs Officer (PAO); Chief, Family Support Division (FSD); Chief, Community Operations Division (COD); Commander, Medical Treatment Facility (MTF); Director, Plans, Training, and Mobilization (DPTM); Civilian Personnel Officer (CPO); Chief, Community Mental Health Service (CMHS); Chief, Community Relations Division (CRD); Alcohol and Drug Abuse Prevention Control Program (ADAPCP)Officer; Field Director, American Red Cross (ARC); Dietitian; Community Health Nurse (CHN)/Nurse Practitioner.

Proponent and exception authority. Not applicable.

Suggested Improvements. Not applicable.

Distribution. Distribution: Active Army, ARNG, USAR: To be distributed in accordance with DA Form 12–9A, requirement for DA Pamphlets, Personnel, General –B, C, D, and E.

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I. Purpose.

This model is intended to provide general guidance regarding implementation, administration and evaluation of the oral health promotion program at the installation level.

II. Applicability.

This guidance applies to installation commanders and members of installation/community health promotion councils. This includes but is not limited to: Director of Personnel and Community Activities (DPCA); Director of Logistics (DOL); Public Affairs Officer (PAO); Chief, Family Support Division (FSD); Chief, Community Operations Division (COD); Commander, Medical Treatment Facility (MTF); Director, Plans, Training, and Mobilization (DPTM); Civilian Personnel Officer (CPO); Chief, Community Mental Health Service (CMHS); Chief, Community Relations Division (CRD); Alcohol and Drug Abuse Prevention Control Program (ADAPCP)Officer; Field Director, American Red Cross (ARC); Dietitian; Community Health Nurse (CHN)/Nurse Practitioner.

III. Background.

a. Dental disease is recognized as a major public health problem. Six percent of the total American health care expenditures are taken up by dental treatment. Historically dental disease has been a significant problem for the military. In Viet Nam 144 soldiers out of every 1000 experienced a dental emergency during his tour of duty. Recently, a decline in caries prevalence has been observed in children. Despite these reductions a sizable amount of need still exists. Within U. S. children 5–17 it is estimated that 21 million restorations are required in primary teeth and 32 million in permanent teeth. Gross reductions in decay in children has brought with it a proportional shift to molar teeth as the principal site of dental caries. In the National Preventive Dentistry Demonstration Program, sealants, which act principally to prevent molar caries, were found to be the most effective preventive measure. The combined measures of water fluoridation, topical fluoride treatments, education, and sealants if vigorously applied within an oral health promotion program could virtually eliminate the incidence of dental caries in children.

b. The National Survey of the Oral Health of Employed Adults and Older Americans (1986) found that fewer Americans were experiencing tooth loss due to caries but with more teeth at risk, a majority of adults also showed signs of periodontal disease. The survey results indicated that 77% of working adults had at least one oral site with periodontal attachment loss of 2mm and 24% had severe periodontal destruction of 4mm or more. But tooth loss from periodontal causes need not occur if an adequate level of oral hygiene is maintained. Education in oral self care measures, combined with routine prophylaxis within an oral disease control program could arrest the advance of periodontal disease in the majority of our adult population.

c. At the onset, no other disease entities are so amenable to personal hygiene and simple preventive therapeutic measures than dental disease. Heightened awareness of the effectiveness of prevention combined with an appropriate behavioral change will reduce the incidence of dental caries and periodontal disease in the military community.

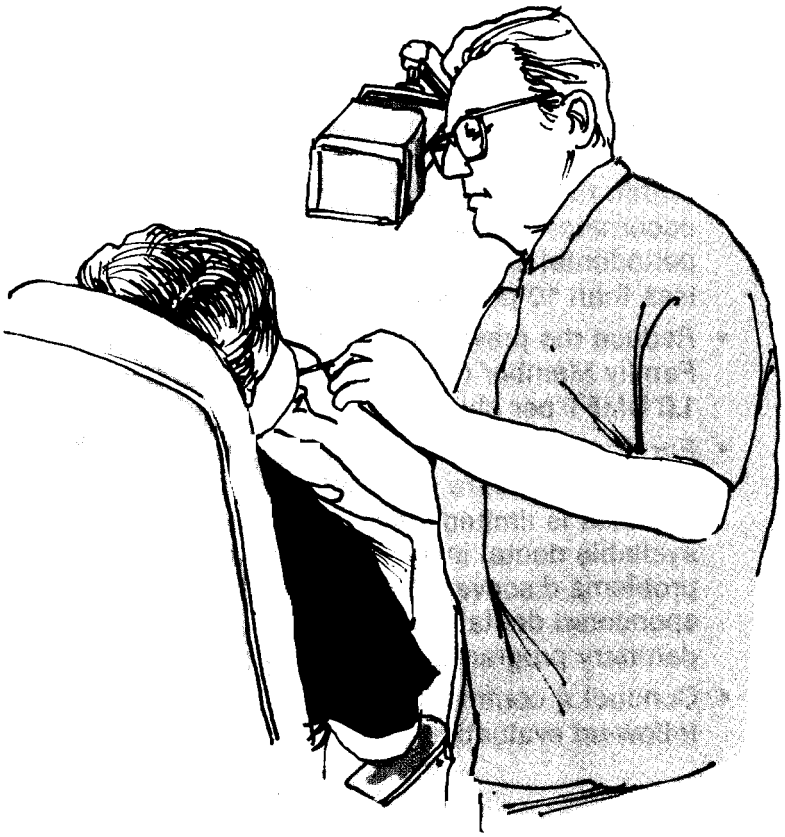

Figure 1. Dental Disease

Figure 2. Preventing Dental Disease

IV. Goals.

• Raise the preventive dentistry awareness of the community to a level where it has an effective knowledge of the causes and prevention of caries and periodontal disease by 1995.
• To provide for participation programs in the use of oral hygiene measures in the eligible beneficiary population.
• Within the active duty, reduce the prevalence of those soldiers with a class 3 dental condition to less than 3 percent by 1995 and 1.5 percent by 2000.

Military Fitness classification
Class 1— Soldier requires no dental treatment
Class 2— Unlikely to have a dental emergency within 12 months
Class 3— Likely to have a dental emergency within 12 months
Class 4— Soldier who needs a dental examination or whose status is unknown

• Within the active duty personnel, reduce the occurrence of one or more sites of severe periodontal destruction to an

incidence of less than 10 percent by 2000.
• Reduce the prevalence of dental caries in Family Member children 7 to 15 years old to 1.0 DMFT per child by the year 2000.
• For nonactive duty community members, where dental care provided in on post facilities is limited, encourage the use of available dental insurance programs to treat problems discovered during service–sponsored dental screening and preventive dentistry programs.
• Conduct a community needs assessment and follow–up evaluation on a continuing basis.

V. Responsibilities.

a. Commanders at all levels are responsible for the oral health promotion program implementation and the accomplishment of objectives, including the evaluation of the program and its impact within their organization.

b. Office of the Deputy Chief of Staff, Personnel (ODCSPER) is the executive staff agent with responsibility for plans, policy, programs, budget formation and research pertaining to the Army Health Promotion Program.

c. Office of the Surgeon General (OTSG) has Army staff responsibility for providing technical assistance required to support the oral health promotion program.

d. Major medical commands have responsibility for providing professional services required to support the oral health promotion program.

e. The Health Promotion Council will, through coordinated efforts of the members, act as the central focal point for program information and advice to the Commander.

f. G3 or DPT will serve as members of the Health Promotion Council and integrate education on dental health in the training schedule.

g. DENTAC commanders will monitor oral health with particular attention to sub–populations at most risk within the command, provide technical consultation regarding education, information training programs, and operate select preventive dentistry programs requiring dental provider supervision and treatment.

h. The Preventive Dentistry/Dental Fitness Officer will serve as the oral health promotion program coordinator, and in concert with the community health dental hygienist, will identify issues that impact on the overall program, act as liaison with community resources, assure that the program is integrated in the overall health promotion program and the CHAMPUS–sponsored dental insurance program, and coordinate assessment and evaluation efforts.

i. Staff Judge Advocate will provide advice and assistance regarding the legal ramifications of the oral health promotion program policy and procedures.

j. The Civilian Personnel Officer will provide representation on the Health Promotion Council and assure that the local programs take into consideration the needs of the civilian work force.

k. Chief of Public Affairs has staff responsibility for conducting the Oral Health Promotion Campaign in the mass media and particularly during annual events such as Children's Dental Health Month.

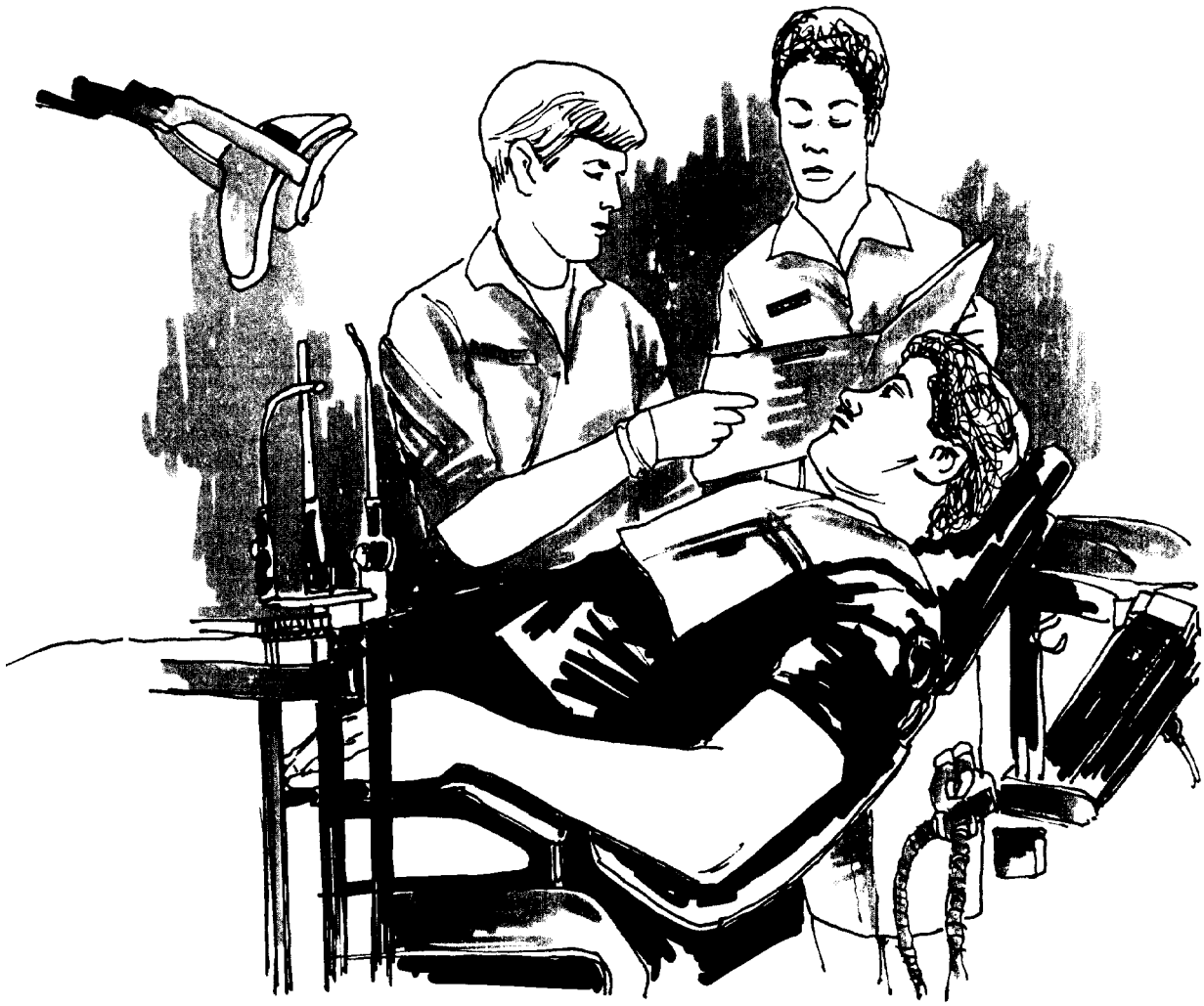

Figure 3. Responsibilities

VI. Module Elements.

The program is comprised of five areas:

a. Needs Assessment
b. Information
c. Education
d. Intervention
e. Evaluation
f. Policy

The program elements are on–going simultaneously and modified appropriately, based on periodic needs assessment and program evaluation.

Table V–2
Suggested Elements for Level 1–2–3 Fit To Win Programs

Modules	Level 1 Program	Level 2 Program	Level 3 Program
Commander's Guide	Introductory Chapter Strategies for program management, and resources	Same as Level 1	Same as Level 1
Marketing	Unit briefings Post media Community needs assessment Posters, slides, videotapes Incentives: —Personal recognition certificates —Awards Evaluation Strategies	Level 1 plus: Guest speakers Promotional items	Level 2 plus: Public relations campaigns Support groups Intramural competitions
Individual Assessment	Automated Health Risk Appraisal Health Risk Review Session	Same as Level 1	Same as Level 1
Physical Conditioning*	Community/unit based programs to include aerobic and strength development classes AR 350–15 Guidance National Fitness Month	Level 1 plus individualized prescription based on fitness evaluation	Same as Level 2
Nutrition and Weight Control	Pamphlets/posters brochures Media blitz for dining hall: menus National Nutrition Month AR 600–9 Guidance	Level 1 plus: Group classes Videotapes Slides/Cassette tape	Level 2 plus: Nutritional Assessment Individualized diet plans Computerized nutritional analysis Cooking classes
Antitobacco	Pamphlets/brochures Media blitz advice for smokers and nonsmokers National Smokeout AR 1–8 Guidance	Level 1 plus: Group cessation programs Videotapes Radio/TV spots	Level 2 plus: Computerized cessation program Support group
Stress Management	Pamphhlets/brochures Posters Welcome Packets with resources within the community Sponsorship Program associated with PCSs	Level 1 plus: Group classes Videotapes Radio/TV spots Commanders session's Unit training Community Skill/Activity Classes	Level 2 plus: Individual treatment programs conducted at medical Treatment Facility
Hypertension Management	Pamphhlets/brochures Unit level Monitoring National High Blood Pressure Month (May) Periodic B.P. checks/follow–ups	Level 1 plus: Group classes Videotapes TV, Radio spots	Level 2 plus: Individual counseling
Substance Abuse Prevention	Pamphlets/brochurs Posters Group meetings and classes AR 600–85 Guidance	Level 1 plus: Videotapes	Level 2 plus: Individual counseling Support groups
Spiritual Fitness	Pamphlets/brochurs Posters Opportunities to meditate, pray, or worship AR 165–20	Level 1 plus: Group meetings classes Developmental activities	Level 2 plus: Individual counseling Referral agencies Values building resources Support groups
Dental Health	Pamphlets/brochurs National Children's Dental Health Month Periodic Dental Examinations Unit Level Dental Fitness Classification Monitoring	Classes Videotapes Radio/TV spots Skills Classes	Individual Oral Hygiene Counseling Definitive Dental Treatment Long Term Follow–Up

Table V–2
Suggested Elements for Level 1–2–3 Fit To Win Programs—Continued

Modules	Level 1 Program	Level 2 Program	Level 3 Program
Procedures Guide	Pamphlets/Brochures/Posters Command Briefings (at least monthly) Incentive/Sustainment Program	Unit Training Schedules which reflect health promotion education classes in all areas needed	Unit Days for: Health Risk Assessment Family Health Promotion Activities

Notes:
* The exercise elements are the most likely to result in untoward events; therefore, cardiovascular screening must be required for all individuals 40 years of age and older and for anyone with a history of cardiovascular disease. A disclaimer is required.

a. Assessment The exercise elements are the most likely to result in untoward events; therefore, cardiovascular screening must be required for all individuals 40 years of age and older and for anyone with a history of cardiovascular disease. A disclaimer is required.

(1) *Objective.* To determine the prevalence of oral disease within the community, to ascertain actual dental health promoting or retarding behavior and factors that reinforce that behavior.

(2) *Strategy.* A community needs assessment should be conducted to determine the extent of the disease prevalence within the community and to target sub–populations most at risk. Dental fitness classification reports should be evaluated to determine dental treatment level needs of the active duty population. Questionnaires may also be useful in identifying individuals whose health beliefs demonstrate a correlation with oral disease. The Health Risk Appraisal questionnaire contains certain epidemiological information on the post population. Those groups particularly at risk are:

- Active Duty Soldiers in Dental Fitness Classes 3 and 4
- Recent Accessions to Active Duty
- Pregnant Women
- Low Socioeconomic Status Individuals
- Individuals whose Dental Status is Unknown
- The Elderly
- Children Consuming Refined Carbohydrates Frequently
- Children of Parents that have Dental Problems
- Low Dental IQ Individuals
- Handicapped Persons
- Medical patients requiring dental therapy as an integral part of the treatment of their medical condition.

(3) Unit level Dental Fitness Reports must be used to assess the oral health of the active duty population.

(4) After determining the extent of the problem and the target groups in the greatest need, appropriate resources should be identified. Ideally, assessment is an on going process to ensure updated, realistic program objectives.

b. Information (Marketing)

(1) *Objective.* Heighten awareness in the Army community to promote change in attitudes and encourage behaviors that promote preservation of oral health.

(2) *Strategy.* Initially target unit commanders and supervisors placing emphasis on the critical impact of dental emergencies on unit effectiveness during wartime and waste of valuable manpower resources during peacetime. Foster role modeling by winning support from community leaders especially the post commander.

(3) Marketing an oral health promoting program requires abandoning the traditional “disease model” which emphasizes preventing negative occurrences and substituting instead the concept that participation produces positive and lasting health benefits. Focus should be placed on the control the individual has over his own, and his child’s, oral health rather than encouraging increased patient demands at the Dental Treatment Facility.

(4) Characteristics of the target population should determine the nature of the program publicity and types of media outlets to be utilized.

(5) Various pamphlets, posters, technical information, and planning resources may be obtained from the National Institute of Dental Research and the American Dental Association.

c. Education

(1) *Objective.* To create a positive image of oral health promoting behavior and teach daily control of dental plaque buildup on teeth, dietary modification, and use of topical and systemic fluoride compounds.

(2) *Strategies.* All publicity and educational efforts should be directed toward the overall goal of provoking interest and stimulating desire in maintaining individual control over dental plaque and control of manageable environmental factors. For active duty soldiers emphasis on the readiness aspects of adequate oral health should be emphasized.

(3) Guidelines for individual, group, and community education strategies should include an explanation defining caries and periodontal disease. Simple effective measures should be prescribed for oral health maintenance. A setting

should be provided in which participants have the opportunity to gain the knowledge, motivation, and skill practice they need to control their oral disease process.

(4) Where possible, every attempt should be made to provide for active participation in plaque control skills.

d. Intervention

(1) *Objective.* To provide preventive education combined with an optional screening program supervised by dental treatment providers to identify individuals at high risk.

(2) *Strategies.*

- Unit commanders identify high risk soldiers (Dental Fitness Class 3 and 4) and refer them for proper diagnosis and treatment to at least Dental Fitness Class 2.
- Other high risk individuals identified during the screening process are referred to applicable health care professionals at a dental treatment facility for appropriate follow–up and/or counseled as to the availability of dental insurance programs to fill their treatment needs.
- A mechanism is provided to ensure follow–up monitoring.
- If follow–up has not taken place the process needs to be reevaluated to determine why follow–up did not occur.

e. Evaluation

(1) *Objective.* To evaluate the effectiveness of educational and self help oral health promotion programs on the values and beliefs of the Army family in order to reduce the risk of dental disease.

(2) *Strategies.* Methods of follow–up to be considered:

Questionnaires or written surveys
Personal or Telephone Interviews
Individual dental plaque control evaluation

(3) Follow–up questionnaires, surveys, and/or interviews over the telephone or in person should be completed on participants in plaque control programs.

(4) Individual plaque control evaluation is an essential part of treatment programs for patients referred as a result of oral hygiene screening programs. Data on short–term and long–term follow–up evaluation of participants' plaque control should be collected. Statistical analysis of these data will indicate program effectiveness.

(5) Unit commanders and supervisors should be well informed so that individuals identified at risk will not remain in a dental class three condition longer than six months.

(6) Dental disease can be controlled and ultimately arrested by practicing effective oral hygiene. For some, this will require lifestyle behavioral changes oriented towards wellness. Health professionals should be aware of their key roles in reinforcing appropriate health behaviors in their patients. Those in the role of significant others, such as parents, play a significant role in reinforcing desired behaviors.

(1) *Process Evaluation.* A process evaluation can be obtained by keeping accurate records of the "Who, What, When, Where, and How" of the program from the beginning. By its very definition, the program of oral health promotion can have no termination only successive stages in which the program is made more effective by intra–program process evaluation.

(2) *Outcome Evaluation.* An outcome evaluation can be made using the results of how the program objectives were attained, e.g. periodic reports summarizing the progress of high risk individuals in their progress towards daily control and subsequent arrestment of dental disease.

Appendix A
Annex A

A–1. Community Dental Needs Assessment.

a. Who needs to be served?

- What is the Dental Fitness Profile of the active duty population?
- How much time is available to provide space available dental care to the nonactive duty population?
- What are the age and socioeconomic demographics of the population?
- What is the prevalence of special "at risk" populations?
- What Services do They Need?
- What services can be provided by the current program?
- What portion of each group is being treated?
- What additional services are needed?

b. Can some services be offered outside the clinical environment?

- Are screening examinations conducted in facilities available in the community?
— Are school screening programs offered?
— Can screening examinations be done for other population groups in community facilities?
- Are education classes offered outside the clinic locations.
- Are such activities accessible to the targeted groups?
- Are there geographical areas that need special programs?

A–2. Title not used.

Paragraph not used.

Appendix B
Annex B

B–1. Estimated Prevalence of Dental Caries and Periodontal Disease.

Your Installation's Response

Dental diseases are ubiquitous and although there are regional variations, national survey data of dental disease prevalence may be used to derive unrefined estimates of the extent of this health problem at the installation level. These estimates will assist you in conceptualizing the problem facing your installation and in implementing appropriate dental disease control strategies in your population.

Part I. Dental Caries

Assuming that approximately your population are under the age of 18, figure as follows: _____ (total population) × 0.33 _____ (child population)

Assuming that approximately are caries free, 63.4% of children will one DMFT figure as follows: _____ (child population) × 0.63 _____ (DMFT population)

Assuming that approximately DMFT involves occlusal surfaces, figure children needing sealants as: _____ (DMFT population) × 0.54 _____ (sealant population)

Part II. Periodontal Disease:

Assuming that approximately your population are over the age of 18, figure as follows: _____ (total population) × 0.66 _____ (adult population)

Assuming that approximately have mild periodontal disease, those needing OHI may be calculated by: _____ (adult population) × 0.77 _____ (OHI population)

Assuming that approximately have severe periodontal disease, those needing treatment and follow-up: _____ (adult population) × 0.24 _____ (periodontal population)

Figure B–1. Estimated Prevalence of Dental Caries and Periodontal Disease

B–2. Title Not used.

Paragraph not used.

Appendix C
Annex C

C–1. Marketing Dental Health Information.

a. In addition to the marketing information contained in the Marketing Module, other suggestions for disseminating dental health information are as follows.

(1) Promote distribution of information to the high risk groups.

(a) Active Duty Soldiers in Dental Fitness Classes 3 and 4.

(b) Recent Assessions to Active Duty

(c) Pregnant Women

(d) Low Socioeconomic Status Individuals

(e) Individuals whose Dental Status is Unknown

(f) The Elderly

(g) Children Consuming Refined Carbohydrates Frequently

(h) Children of Parents that have Dental Problems

(i) Low Dental IQ Individuals

(j) Handicapped Persons

(k) Medical patients requiring dental therapy as an integral part of the treatment of their medical condition.

(2) Disseminate general information regarding the nature of dental disease. Easily targeted audiences are church organizations, parent–teacher organizations, wives' clubs, schools, and scouting programs.

(a) Most dental disease is 'silent' until it creates an emergency situation.

(b) Dental disease is easily preventable.

(c) The progress of dental disease can be controlled by the individual.

(d) Simple dietary modification can drastically alter the incidence of caries.

(e) Plaque control is simple to accomplish using whatever devices are easiest for the patient to use.

(f) Dental care is not expensive, dental neglect is.

(g) Dental insurance programs are available to help defray costs of dental care when it is not available on a space available basis.

(3) Distribute available posters and flyers, and use public information channels as often as necessary to keep awareness at a high level.

(4) Support National Childrens' Dental Health Month in cooperation with the American Dental Association and local dental organizations.

(5) Use local public service announcements, news releases and bulletins.

(6) Coordinate with local Personnel and Finance offices to keep them aware of the availability of space available dental care and the availability of care on government.

b. Implementation Strategy Development

(1) Clearly delineate the activities and appoint a single person as the overall coordinator.

(2) Identify needed materials and sources

(3) Identify local methods for information distribution.

(4) Consult with organizations which will be affected by these activities and resolve conflicts.

(5) Identify resources and constraints and initiate any actions necessary to rectify any shortfall in available resources.

Table C–1
Resource Identification

Resource	Source
People	
Supporters	
Unit Level	
Post Level	
Military Community	
Civilian Community	
Providers of Information	
Providers of Services	
Staff Skills and Time	
Dental	
Organizational	
Planning	
Clerical	
Educational	
Analytical	
Equipment	
Examination Chairs, Lights, etc.	
Examination Equipment	
Clerical Supplies	
Data Processing	
Data Storage	

C–2. Title not used.

Paragraph not used.

Appendix D
Annex D

D–1. Education.

Community education can be managed through the following modalities.

1. Training. Provide general information classes concerning dental health and its effect on readiness in unit training schedules. (Level 2)
2. Command Information Briefs. Provide information briefs to personnel in leadership positions which highlight the importance of oral health and its relation to readiness and family morale.
3. Classes. Provide oral health information to the community via local closed circuit television, "Health Promotion Nights", or community meetings. Potential class topics include:
   a. Causes of dental disease.
   b. Plaque removal.
   c. The importance of periodic oral examinations.
   d. Oral health effects of tobacco products (including smokeless tobacco products).
   e. Self examination for prevention of oral cancer.
   f. Dietary influences on dental disease.
   g. Preventive dental procedures.

   Educational tools such as video tapes, posters, fliers, marketing newsletters, books, and periodicals are available through the American Dental Association as well as the various dental specialty organizations.
4. Speakers should be scheduled at times and places convenient to the target audience.

D–2. Title not used.

Paragraph not used.

Appendix E
Annex E

E–1. References/Resources.

1. U.S. Department of Health and Human Services. The Prevalence of Dental Caries in United States Children, The National Dental Caries Prevalence Survey. NIH Publication No. 82–2245, December 1981.
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E–2. Title not used.

Paragraph not used.

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DOCUMENT: DA PAM 600–63–11
DOC STATUS: NEW PUBLICATION